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The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

This letter report presents the results of a follow-up review the Bureau of State Audits (bureau) conducted concerning the efforts of the Provider Enrollment Division (division), within the Department of Health Care Services (department),[1] to implement the recommendations from a report the bureau issued in April 2007 titled *Department of Health Services: It Needs to Improve Its Application and Referral Processes When Enrolling Medi-Cal Providers* (2006-110). During the follow-up review, we focused on findings related to the division's communication with applicants, its data management, and its policies and procedures. While the department implemented six of our recommendations, it could not demonstrate it implemented the remaining six.

The department has not consistently followed its policies that were developed to ensure the accuracy of the data within its Provider Enrollment Tracking System (PETS). Errors we found could potentially have a material effect on the classification of providers and the date an application was approved. Further, the division has not removed test data from PETS, the continued presence of which calls into question the integrity of the division's provider enrollment data. The division also has not demonstrated that it has addressed a backlog of older referrals, or that it promptly notifies applicants when it automatically enrolls them as provisional providers. In addition, the department performed only limited reenrollment of its providers since our 2007 report, and did not demonstrate it had monitored Medicare's revalidation process.

Background

In 2006 the Joint Legislative Audit Committee (audit committee) requested that the bureau review the department's Medi-Cal provider enrollment process, as well as the laws, rules, and regulations governing it. Specifically, we were asked to do the following:

- Compare the application and enrollment procedures for Medi-Cal and Medicare providers and determine whether opportunities exist for sharing additional information to streamline the enrollment process.

[1] Our report 2006-110 referenced the Provider Enrollment Branch within the Department of Health Services. On July 1, 2007, the Provider Enrollment Branch became the Provider Enrollment Division. Also on July 1, 2007, the Department of Health Services was reorganized and became two departments—the Department of Health Care Services and the Department of Public Health. The Department of Health Care Services is now responsible for the Medi-Cal program. To limit confusion, in this follow-up review we reference these entities by their current names: the Provider Enrollment Division and the Department of Health Care Services.

- Determine whether the department tracks and monitors the average time it takes to review a physician application and identify the number of full-time staff assigned to review physician applications and the number of hours allocated for each review.

- Identify the number of applications denied over the previous year and the reasons for those denials.

- Review the department's procedures for handling deficient applications and identify the type of information that is most often missing from these applications.

- Identify the number of applications referred to the department's Audits and Investigations Division in the previous year, the reason for each referral, and the number of referred applications that were denied.

- Identify the number of applicants requesting preferred provider status in the previous year and categorize this information by the department's enrollment decision, physician specialty, and geographic location.

- Identify the total number of applicants awaiting enrollment into Medi-Cal; determine the total number of applications the department did not process within the designated review period; and categorize each group by provider type, specialty, geographic location, Medicare enrollment status, and application type.

In April 2007 we issued our report, concluding that the division did not process some applications within the time periods specified in statute and that division staff entered inaccurate data into PETS, decreasing its ability to effectively track the status of applications. Additionally, some applicants resubmitted information to remedy their deficient applications soon after the designated time period lapsed. State law required the division to deny these applications and treat them as new, delaying otherwise eligible providers from offering services to Medi-Cal recipients. Also, because few applicants requested preferred provider status and the division had a low average time for processing applications in federal fiscal year 2006, we concluded that the status offered applicants few benefits.

Further, we discovered that the division did not adequately track to which of the department's review units it referred applications or the reasons for these referrals. Moreover, state law does not prescribe a required number of days within which the division must approve or deny an application it refers for further review, and we noted that referred applications took an inordinate length of time to

process. In addition, the fraud indicators used by the division to process applications that appeared questionable or suspicious generally did not align with the reasons the division ultimately gave for referring applications in PETS—hindering its ability to track the legitimate reasons it had for referring applications and decreasing its capability to detect potential fraud trends during the enrollment process. Finally, because physicians applying to become providers in Medi-Cal and Medicare were asked to provide much of the same information, and given that the federal government was beginning two initiatives to ensure that more accurate and updated information was available about Medicare providers, we noted it would be worthwhile for the department to periodically assess Medicare's progress to determine whether there would be benefits to relying on some of Medicare's data in the future.

Based on the authority granted to the bureau, the bureau must require each agency or department we audit to report to us on its progress in implementing our recommendations at intervals prescribed by the State Auditor (California Government Code, Title 2, Chapter 6.5).

While the Division Indicated It Has Implemented Our Recommendations, in Six Instances We Were Unable to Validate These Assertions

In six instances the department has not fully addressed the concerns raised in our April 2007 report.

Although the department indicated in its responses to our audit that it had implemented our recommendations, in six instances we were not able to gain assurance that our concerns were addressed. Specifically, the department did not consistently follow its new policies to ensure the accuracy of its data, and our accuracy testing revealed several exceptions in the PETS data. Further, the division has not maintained the integrity of PETS by removing all test records from the system. The division also has not demonstrated that its increased emphasis on processing applications referred for further review within a reasonable time has addressed a backlog of referrals, some of which are nearly three years old. It has also not demonstrated it promptly notifies applicants when it automatically enrolls them as provisional providers. In addition, the division performed only limited reenrollment activity since our 2007 report, and it cannot demonstrate that it monitored Medicare's revalidation process.

The Division Has Not Consistently Ensured the Accuracy of Data Entered Into PETS

We reported in April 2007 that division staff continued to omit dates and enter incorrect dates into PETS. Specifically, 96 of the 179 applications that the division appeared to process late contained errors, such as incorrect dates of receipt, duplicate records, and applications that appeared to be denied yet were still in process. These errors hinder management's ability to accurately track the status of these applications. This same problem was also noted in the bureau's audit reports published in May 2002 and December 2003. We recommended in April 2007 that division management include in the secondary reviews of applications periodic reviews to ensure that staff are accurately and consistently entering into PETS the correct dates the branch received, processed, or returned the application.

The division indicated in its one-year response that it had completed updates to its procedure manual in December 2007 to ensure correct dates were entered into PETS. It also stated that its managers review for accuracy all data entered into the tracking system throughout the application process.

Although the division indicated that managers review for accuracy all data entered into PETS, we found that these periodic reviews were not documented in accordance with its procedure manual and also found some errors during our data accuracy testing.

The division's procedure manual outlines the responsibilities of managers and supervisors in both the processing units and program support units for reviewing staff work. These responsibilities include periodic review of the data entered into PETS by division staff and documentation of those reviews in certain instances. However, while the division section chiefs stated that their unit managers conduct reviews of staff work, we found that these periodic reviews were not documented in accordance with the procedure manual. As such, we were not able to validate the extent to which these reviews occurred.

One section manager indicated that her former unit managers did not have time to implement the new policy, she was without unit managers for a substantial period of time, and her new managers have not yet been trained in the process. However, the division indicated the start dates for these managers ranged from October 2007 to June 2008, and we believe it is a reasonable expectation that these managers learn and implement these guidelines within the first four months in their new position.

Our data accuracy testing again found several errors. In our sample of 50 applications (over 300 total data elements tested), we found six critical errors—three in the field describing the type of provider (for example, an osteopath or a durable medical equipment provider) and three in the field describing when an application was

approved.[2] These six errors could potentially have a material effect on the classification of the provider and the date an application was approved. Because the data could lead to an incorrect or unintentional message, these weaknesses are potentially significant, and the data related to provider type and application approval date are not sufficiently reliable.

The chief of the division indicated that the incorrect data in the field describing the provider type were due to human error, and that based on the volume of work, these types of human error could be expected. He further indicated that the errors in the field describing when an application was approved were due to PETS' internal controls that prevent staff from manually entering the date an application was approved, but rather automatically records the date staff complete an entry within PETS. Nevertheless, the electronic data in PETS did not reflect hard-copy records. In one case, an 11-day difference occurred. Based on the error rate we found, we cannot be 95 percent confident that there is less than a 10 percent error rate in the provider type and approval date field.

The Presence of Testing Data Within PETS Continues to Call Into Question the Integrity of the Division's Provider Enrollment Data

We reported in April 2007 that PETS contained fictitious provider records resulting from staff training and testing exercises. We identified 166 fictitious provider records in data provided by the division. To protect the integrity of PETS data, we recommended that the division remove all staff training and division testing data from PETS and place it in a simulated environment.

The department indicated in its one-year response that removal of all training and testing data from PETS was completed in August 2007. Division management indicated that, since the previous audit, it has been more cautious about entering test data into the system and has decreased the amount of hands-on training in PETS, it now trains staff in large groups, and it uses live PETS records instead of test data during training. The division also stated that test data is identifiable within PETS in multiple ways. For example, test data might include a department address within the address field, a provider number that ends with a "T," a provider name field that indicates in the name that the data is test data, or a provider number that consists of a repetition of the same number (like 444444444).

To protect the integrity of the provider enrollment data in PETS, division management indicated that, since the previous audit, the department has been more cautious about entering test data into PETS. However, we identified 346 records that contained test data.

[2] Beyond the six errors described here, we found two additional errors that, because they were within our tolerable error rate for their respective fields, did not have a material effect on our determination of the accuracy of PETS.

However, the division has no single way to consistently identify test data. A division section chief stated that to determine whether test data exists in PETS, she prints reports and searches for the items previously noted, as well as anything else that looks suspicious. We question the effectiveness of this effort, because during our review we identified 346 records that contained test data in two separate tables within PETS. The presence of this data continues to call into question the integrity of provider enrollment data coming from PETS.

The Division's Increased Efforts to Process Applications Referred for Further Review Within a Reasonable Time Have Not Yet Produced Results

In our April 2007 report we described how the department took an inordinate amount of time to process some applications that the division refers to the department's Audits and Investigations Division for further review (referrals), even though many of the referrals were ultimately approved. We recommended that the division and the Medical Review Branch (branch), with direction from the department, place increased emphasis on processing those applications within a reasonable time period to ensure that some eligible Medi-Cal providers are not unreasonably delayed in providing services to beneficiaries.

In its one-year response, the department indicated that it implemented procedures in June 2007 to ensure that applications referred for comprehensive review were processed within 60 days of receipt of the on-site report from the branch. In addition, it indicated that the division would contact the branch six months after a referral was made to obtain the status of any outstanding cases. It also indicated that the division would reconcile outstanding cases with the branch quarterly.

We asked the division for documentation it used to determine the status of outstanding cases and for the quarterly reconciliation reports. The department was able to provide e-mails indicating that the division and branch are engaging in ongoing communication regarding outstanding cases. The e-mails included spreadsheets in which the division and branch reconciled information on outstanding cases. However, between June 2007 and June 2008, the department was only able to demonstrate that a reconciliation of outstanding cases occurred for three of the four quarters.

In our previous report, we found that, as of September 2006, three referrals for federal fiscal year 2004 were still in process at least two years after the division referred them to the branch. As of September 2007 PETS data indicate that 75 referrals from federal fiscal year 2005 were still in process at least two years after the

referrals were made. This represents a major increase in the backlog of referrals that are at least two years old. Although the division indicates it implemented our recommendations in June 2007, we found that 50 of these 75 referrals were still in process as of June 2008. The Table shows the inventory of referrals still in process from federal fiscal years 2005, 2006, and 2007.

Table
Inventory of Applications Referred for Further Review and Still in Process

FEDERAL FISCAL YEAR	TOTAL APPLICATIONS REFERRED*	INVENTORY OF APPLICATIONS REFERRED FOR FURTHER REVIEW BUT STILL IN PROCESS AS OF THE FOLLOWING DATES:		
		SEPTEMBER 30, 2006	SEPTEMBER 30, 2007	JUNE 30, 2008
2005	919	134	75	50
2006	596	278	41	25
2007	274	NA	138	40

Sources: Provider Enrollment Tracking System data, Bureau of State Audits' Report 2006-110.

Note: As mentioned in the prior subsection on accuracy testing, we found errors that could lead to an incorrect or unintentional message. These weaknesses are potentially significant and render the data not sufficiently reliable for purposes of determining the date an application was approved and the number of applications in process as of a particular date.

NA = Not applicable.

* These numbers may include some applications belonging to a provider group that the division typically refers, denies, approves, or returns concurrently as a cluster. Thus, the total number of applications may be greater than the numbers in these columns.

We asked the division to explain the status of the 50 referrals outstanding as of June 2008; the division chief explained that 42 are referrals sent to the Department of Public Health's Laboratory Field Services (field services) and that the remaining eight were referrals sent to the branch. The division chief told us that referrals sent to field services were the result of a project undertaken in 2004 to correct the problem of laboratories operating under individual physician or group physician numbers, rather than enrolling as laboratories. The division asked the laboratories to submit the proper applications, which the division then referred to field services. The division chief explained that field services continues to view these referrals as low priority and the referrals remain outstanding. However, the division chief stated that these providers continue to get reimbursed under their existing provider numbers and therefore this problem does not result in an access-to-care issue for Medi-Cal recipients. In a November 2008 statement, the division chief explained that the branch has resolved its eight outstanding referrals by forwarding to the division one of the referrals for approval and the other seven for denial.

Although the division indicates that the referrals to the branch have been resolved, the eight referrals that were outstanding as of June 2008 do not give us assurance that the division addressed our original recommendation because even these eight—excluding referrals to field services—represent an increase from the three referrals at least two years old found in our April 2007 report. It is also apparent that the division needs to resolve the 42 outstanding referrals to field services.

The Division Has Not Demonstrated It Promptly Notifies Applicants When It Automatically Enrolls Them as Provisional Providers

In our April 2007 report we found that between October 2005 and September 2006, 108 applications had not been processed within the various required time periods outlined in statute. The division did not notify or automatically enroll 100 of these applicants, which may have prevented or delayed some eligible providers from delivering services to Medi-Cal beneficiaries. We recommended that the division promptly notify applicants that it has automatically enrolled them as provisional Medi-Cal providers when it has not processed the application within the required time periods.

In its one-year response, the department stated that the division developed a letter and implemented a process to immediately notify applicants who had been automatically enrolled; in addition, procedures to immediately notify these applicants were added to the division's procedure manual.

The division designed procedures to help ensure that prospective providers are promptly notified when their application is not processed within the required period, referred to as being in default. The division explained and provided examples of how it runs weekly aging reports, showing the status of open applications within the system and identifying any applications that have recently defaulted or are in imminent danger of doing so. According to the procedure manual, division analysts are to prepare notifications within 24 hours of identifying defaulted applications.

Despite its new procedures, the division could not show it immediately notified applicants upon automatic enrollment.

However, despite its procedures, the division could not show it immediately notified applicants upon automatic enrollment. The division provided us with a report displaying the 15 applications it believed had defaulted between May 2007 and October 2008. We narrowed this list to 10 because, upon further review, we found that four had not actually defaulted and one could not be sent a notification letter upon default because the department discovered that the application did not have documentation confirming that the applying entity actually existed. For the remaining 10 applications, the department could only locate two letters, and these were

dated 138 days and 97 days after the default of their respective applications. Because the information the department could provide was so limited, and because that evidence did not suggest that the department is notifying providers with defaulted applications immediately, we do not have assurance that the division's procedures in this area are being effectively carried out.

The Division Has Performed Limited Reenrollment Activity Since Our 2007 Report

In our April 2007 report we described how the department had not established a goal or timeline by which it planned to reenroll all providers. We concluded that although the streamlining of its physician application process may not provide large savings on an individual application basis, the cumulative savings could be significant. To that extent, the division could allocate more staff resources to reenrolling current Medi-Cal providers, which in turn could allow it to reenroll all providers sooner. We recommended the division continue its plans to reenroll all its Medi-Cal providers and add any resources freed up by the streamlining of its enrollment process to this effort.

In its one-year response, the department indicated that it has continued its ongoing reenrollment of providers. It asserted that it would use a soon-to-be-completed study to identify providers for reenrollment that are at the highest risk for committing fraud, waste, and abuse. It also indicated that the next phase of reenrollment would be based on this identification in conjunction with other input from the department's Audits and Investigations Division.

Although the division initiated a new reenrollment phase in February 2007, information provided by the division indicates that it has not initiated another phase since. Unaudited data provided by the division indicates that in the 14-month period from February 2007 through March 2008, it reenrolled approximately 29 providers per month. However, in the seven-month period from April 2008 through October 2008, it reenrolled approximately four providers per month.

The division indicated that, due to provider confusion resulting from the recent implementation of the National Provider Identifier, a unique identification number used to identify health care providers in various transactions, its enrollment workload has increased, and it redirected staff from reenrollment activities to help manage this increase. The division further indicated that, as the enrollment application inventory is brought down to a

The division has performed limited reenrollment activities partly because it redirected staff from reenrollment activities to help manage an increase in the enrollment workload.

manageable level, staff will return to reenrollment activities. However, the division was unable to provide a timeline for when this might occur.

The Division Could Not Demonstrate That It Has Monitored Medicare's Revalidation Process

According to our April 2007 report, as of November 2006, federal regulations require Medicare providers to resubmit and recertify the accuracy of their enrollment information every five years in order to maintain their billing privileges. Because applicants seeking to become physician providers in Medi-Cal and the federal Medicare program are asked to provide much of the same information in their application packages, we observed that the department may have the opportunity to streamline some of its enrollment processes for Medi-Cal applicants who are already Medicare providers by relying more on Medicare provider information. We recommended that the division monitor the implementation of Medicare's revalidation process in which it verifies the enrollment information for all its providers to identify opportunities for streamlining its application and verification procedures and make modifications as appropriate for Medicare providers seeking enrollment in Medi-Cal.

In its one-year response, the department indicated that it was monitoring Medicare's revalidation process. However, the division was unable to substantially demonstrate to us that it has conducted the monitoring. According to the division's policy and administrative section chief, the staff member assigned to track the Medicare revalidation process no longer works for the division, and the division has no access to this former staff member's original research supporting the statements in the department's response. Further, since the staff member's departure in early 2008, the division has not assigned the responsibility of tracking Medicare's revalidation process to another division employee.

The division provided us limited evidence that it monitored the proposed changes to Medicare's application process. It asserted that it met with the Medicaid Integrity Group, a unit within the Centers for Medicare and Medicaid Services (CMS) to discuss validation and revalidation best practices. However, it could provide no agenda or other documentation for this meeting. The division did provide a CMS conference itinerary for a project to unify the applications for Medicare, the federal health insurance program, with those of Medicaid, the federal and state program of medical assistance (known as Medi-Cal in California). However,

our recommendation was specific to monitoring the new Medicare revalidation process, and we could not see anything on the conference itinerary directly related to this process.

The division chief explained that the department had an employee tracking the revalidation process at one time, but this was never the sum total of all the Medicare monitoring taking place within the department. In fact, the department has been monitoring changes occurring in Medicare's application and revalidation processes on an ongoing basis. While the division was not able to provide the type of documentation that would satisfy us that this monitoring took place, the division chief explained that the department has no pressing business reason to document the Medicare bulletins and web-page updates that its managers are reading on a continual basis, and the department has no pressing business reason to create formal analyses to support its assessments of Medicare's processes. The division chief stated that the department is satisfied that it has implemented both the spirit and letter of the original recommendation and sees as unfortunate the conclusion that the division could not demonstrate this to our satisfaction. Nevertheless, to comply with audit standards, we must have sufficient evidence to support our conclusions and in this case the division could not provide this level of evidence.

The Department and Division Have Implemented Six of the Recommendations From Our Previous Audit

The department and division implemented the following six of 12 recommendations from our April 2007 audit:

- The department supported legislation to extend the application remedy period from 35 days to 60 days.
- The division increased its efforts to inform applicants that they must use current and appropriate forms to complete applications.
- The division increased its efforts to notify preferred provider applicants of the reasons why it might deny an application.
- The division met regularly with the branch to review and update its list of high-risk fraud indicators.
- The division aligned the reasons in PETS for which it might refer an application with this list of high-risk fraud indicators.
- The division implemented procedures to track applications sent to its policy unit for denial.

The Department Supported Legislation to Extend the Application Remedy Period to 60 Days

In April 2007 we reported that the main reason for denial was because applicants did not promptly resubmit deficient applications. The branch denied 53 percent of applications because the applicants failed to resubmit them within the required 35-day period or did not resubmit the applications at all. The federal Medicare program gives applicants 60 days to remedy their deficient applications. We stated in our previous report that this additional time could benefit Medi-Cal applicants who resubmit their applications shortly after the 35-day deadline, and recommended that the department seek legislation to revise state law to extend the time period applicants have to remedy deficiencies in their applications to 60 days.

In October 2007 the governor signed into law a provision extending the remedy period for applications from 35 days to 60 days.

In October 2007 the governor signed into law a provision extending the remedy period for applications from 35 days to 60 days. This provision, which the department supported, became effective in January 2008. The division indicated that a bulletin informing providers of the change in statute was published in the December 2007 *Medi-Cal Update* and posted on the Medi-Cal Web site. We verified that this bulletin was currently on the Medi-Cal Web site.

The Division Informed Applicants Via Its Web Site That They Must Apply Using Current and Appropriate Forms

In April 2007 we reported that the second leading reason for denial of applications was the submission of outdated or incorrect forms. The department stated credentialing departments that fill out applications on behalf of providers may have an inventory of old applications in stock. However, the department's Web site gave no indication that using outdated and inaccurate forms was one of the main reasons the department denied applications. To ensure that the division does not unnecessarily increase its workload or prolong the enrollment process for eligible applicants, we recommended that it increase its efforts to notify applicants that they must use current and appropriate application forms to avoid being denied enrollment into Medi-Cal.

The department stated that it updated its Web site to inform applicants that they must use current and appropriate application forms and that it updated its Top Reasons Provider Enrollment Applications Are Denied (Top Reasons) document to include this information. We verified that the division updated both the Top Reasons and Medi-Cal Provider Enrollment Frequently Asked Questions documents to include this notice.

Although It Did Not Seek Legislation Eliminating Preferred Provider Status Applications, the Department Did Increase Efforts to Tell Applicants Reasons for Denial

Our April 2007 report noted the only benefit gained from the preferred provider status is a reduction in allowable processing time from 180 days to 90 days. However, the average number of days the division took to process an application during federal fiscal year 2006 did not exceed 69 days. We therefore recommended the department seek legislation to revise state law to eliminate preferred provider status. Alternately, we recommended that if it chose to keep this status, the department should increase its efforts to notify applicants of the reasons it denied applications during the prescreening for preferred provider status.

In its one-year response, the department stated that physicians should be allowed the opportunity to weigh the costs and benefits of enrolling as a preferred provider and that it would only seek the elimination of preferred provider status with the cooperation of the California Medical Association. It further stated that it has completed an analysis of denied preferred provider applications and is developing a list of frequently asked questions regarding applying for preferred provider status, which would include information on why preferred provider applications were most commonly denied.

The division updated its Web site to include a document that warns prospective preferred providers of the top five reasons it denies these types of applications. These reasons include incomplete documentation and application packages and prospective providers that do not meet the criteria for the appropriate application type.

The division has updated its Web site to include a document that warns prospective preferred providers of the top five reasons it denies these types of applications.

The Division Met Regularly With the Branch to Reevaluate and Update the High-Risk Fraud Indicator List

The division may refer applications to other units within the department, or to analysts within the division itself, in order to conduct background checks to verify the accuracy of information provided to the department, and to prevent fraud and abuse if it finds discrepancies during the enrollment process. In our April 2007 report we demonstrated that the division was referring applications that it later approved, indicating that it may need to reevaluate and update the high-risk indicators used for processing applications. Further, we found that for the previous six months the division had not held regular meetings with the branch, which served to foster information sharing between the two groups. To ensure that it is referring those applicants at greatest risk of committing fraud while not preventing eligible Medi-Cal providers from providing services to beneficiaries, we recommended that

the division and the branch, with direction from the department, reevaluate the appropriateness of the division's high-risk fraud indicators periodically by consistently communicating and collaborating with one another.

The department indicated that the division and the branch reconvened the previously established monthly meetings to continue the review of high-risk fraud indicator checklists for appropriateness. Our testing found that the division and the branch met regularly between April 2007 and July 2008 to do so. Further, the division has updated the high-risk fraud indicator list since our April 2007 report.

The Division Aligned PETS Reasons for Which It May Refer an Application With Its High-Risk Fraud Indicator List

Our April 2007 report found that although the division used specific review checklists and fraud indicators to process applications that appeared questionable or suspicious, they generally did not align with the reasons the division ultimately gave in PETS for referring applications. Although division staff attached a memorandum to each application they referred for further review, describing the reason for the referral and outlining the specific items to be addressed in the secondary review, these reasons were not captured in PETS. We recommended that the division, with direction from the department, align the reasons available in PETS with its fraud indicators and high-risk checklists to better track the appropriateness of its high-risk checklists. We further recommended that the division update the fraud indicators as trends in fraud change over time.

The department's fraud risk indicator work group updated its high-risk fraud indicators list and updated the appropriate tables in its tracking system.

The department stated that a fraud indicator work group, consisting of division and branch staff, reviewed the list of high-risk indicators and identified changes that needed to be made to PETS. It further stated that a list of referral reasons was established in February 2008 and an update to the referral reasons table in PETS was completed in March 2008. As noted earlier, the division collaborated with the branch to update its high-risk fraud indicators list. During our follow-up we confirmed that the referral reasons list in PETS matched the updated fraud indicators list.

The Division Implemented Procedures to Track Applications Sent to It for Denial

In our April 2007 report we described how the division did not track the amount of time applications remained in the policy unit and that this caused it to automatically enroll some applicants whose applications were recommended for denial. We recommended that the division modify PETS data to track the length of time applications it recommends for denial remain in the policy section for review to ensure that it does not automatically enroll or pay the claims of ineligible providers when the review does not occur in a timely manner.

In its one-year response, the department indicated that the division modified PETS to include tracking capability to ensure that no applications subject to denial in the policy unit would be allowed to default. The department indicated that procedures were developed and implemented, and that a policy denial report was reviewed on a weekly basis. We confirmed that the division modified PETS to track applications sent to the policy unit for denial, and that the policy unit implemented procedures to track these applications. The policy unit uses a report on a weekly basis to review the status of applications within the unit. The report includes information such as when an application will default and whether an application was referred for an on-site visit.

We conducted this review under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. We limited our review to those areas specified in the background section of the letter report.

Respectfully submitted,

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